Department of Public Health
Bureau of Substance Abuse Services
APPLICATION FOR A
SUBSTANCE ABUSE TREATMENT LICENSE FOR A
DEPARTMENT OF MENTAL HEALTH LICENSED FACILITY

INSTRUCTION

Completion of Application: Carefully review the entire application package before completing the application.

Applicants must be in compliance with requirements of Appendix B of 105 CMR 164 Licensure of Substance Abuse Treatment Programs. Submission of an application constitutes affirmation that applicant is fully compliant with these requirements.

Applications must be completed as follows:

1. Complete information requested on pages 1 and 2.

2. Complete all items. If an item is not applicable to your program, note "N/A" in the space provided or in the listing of Tabs (application documentation).

3. The "Attestations and Certifications" section on page 2 must be signed in ink by the specified applicant authorities.

5. Signatures must be witnessed and confirmed by a notary public.

6. The listing of required application documentation begins on page 3. Information requested must be provided in the form and order specified -- that is, narrative descriptions when instructed to "describe" and forms, policies, certificates, etc. attached when required.

7. Tables included with this package must be used to record requested information; applicants may make copies of these tables as needed. All required tables are at the end of the application. Insert completed tables in the application under the appropriate Tab.

8. Enter applicant program name in the space provided at the top of each page.

9. Each documentation item must be numbered as specified in the "Tab No." column. Note that the relevant regulatory section is listed in the right hand column to assist applicants in ensuring that the documentation provided complies with regulatory requirements. If a Tab is not applicable to your program, include a page listing the Tab Number and noting that it is "N/A."

10. Application documentation must be assembled in the order listed, with tabbed dividers between each numbered item.

11. Do not staple or bind documentation.

Submission of Application:

1. Copy pages 1 and 2, and send them with the application fee of $300 to the address below. Please make the check payable to "DPH":

   Department of Public Health
   Bureau of Substance Abuse Services
   250 Washington Street, Third Floor
   Boston, MA 02108
   Attn: Gerry Romano

2. Send the original of pages 1 and 2, and all application documentation to the licensing inspector for your region as follows:

Metrowest:

Judi Robbins
Licensing Inspector
DPH Metrowest Regional Office
5 Randolph Street
Canton, MA 02021
781-828-7909
TTY: 781-828-7277
FAX: 781-828-7703

Greater Boston:

Ben Sullivan
Licensing Inspector
DPH Greater Boston Public Health Office
10 Malcolm X Blvd.
Roxbury, MA 02119
617-541-8306
TTY: 617-541-8314
FAX: 617-541-2861

Central & Western:

Erica M. Piedade
Licensing Inspector
DPH Western MA Regional Health Office
23 Service Center
Northampton, MA 01060
413-586-7525, x1182
TTY: 800-769-9991
FAX: 413-784-1037

Northeast:

Ann Canavan
Licensing Inspector
Northeast Regional Health Office
Tewksbury Hospital
365 East Street
Tewksbury, MA 01876
978-851-7261, x 4023
TTY: 978-851-0829
FAX: 978-640-1027

Southeast:

Ruth Karmelin-Bice
Licensing Inspector
DPH Southeast Regional Health Office
1736 Purchase Street
New Bedford, MA 02740
508-984-0624
TTY: 508-984-0636
FAX: 508-984-0605

Department of Public Health
Bureau of Substance Abuse Services
APPLICATION FOR A
SUBSTANCE ABUSE TREATMENT LICENSE FOR A
DEPARTMENT OF MENTAL HEALTH LICENSED FACILITY

Program Legal Name:			
Program Location Address: Street:			Tel: TTY/TDD: Fax:
City:	State: Massachusetts	Zip:	
Program Mailing Address: **NOTE: This is the address BSAS will use to send license and all other notices.** Street:			Tel: TTY/TDD: Fax:
City:	State: Massachusetts	Zip:	
Applicant (Corporate) Legal Name:			
Applicant (Corporate) Mailing Address: Street:			Tel: TTY/TDD: Fax:
City:	State:	Zip:	

Applicant Organization Type:

☐ Commonwealth of Massachusetts Department, Agency or Institution

☐ Corporation, specify whether: ☐ For Profit, or ☐Not for Profit (attach 501 C(3) certificate) Incorporated in (state):

☐ Partnership ☐ Sole Proprietor ☐ Other: specify:

EIN/TIN:

Licensing Application For: ☐ New Program ☐ Existing Program (Renewal)

Is program funded by BSAS? ☐ **Yes** ☐ **No**

CURRENT LICENSES, APPROVALS and ACCREDITATIONS: Complete the table below. Enter "N/A" if license, approval or accreditation is not applicable. Include copies of licenses, approvals and accreditations in **Appendix A** of the application, using numbered tabs as listed below.

Appendix A Order	Licenses/Approvals	License/approval No.	Expiration Date
1	MA-DPH/BSAS License:		
2	MA-DPH/DHCQ:		
3	MA-DMH		
4	MA-FD Controlled Substance Registration		
5	MA-FD Controlled Substance Registration for Suboxone		
6	US-DEA Controlled Substance Registration		

Accreditations: Identify accrediting body:		**Dates of Current Accreditation** Start	End
7	**Joint Commission** (formerly JCAHO)		
8	**CARF**		
9	**COA**		
10	**Other:**		

Program Name: **Application Date:** MO_____ YR_____

SERVICES PROVIDED

☐**ACUTE SERVICES:**

☐ **MEDICALLY MONITORED INPATIENT DETOXIFICATION**

No. of beds:

Check if providing, directly or through QSOA: ☐ Methadone ☐ Suboxone

Special Populations:

☐ Adolescent ☐ Pregnant Women

☐ Persons with co-occurring disorders

RESPONSIBLE OFFICIALS

Officer of Governing Body: *(e.g. president, chairperson of board)*		**Title:**	
Street Address:			T el :
City:	State:	Zip:	Fax :
Email address:			
Executive Director:			
Street Address:			T el :
City:	State:	Zip:	Fax
Email address:			
Program Director:			
Street Address:			T el :
City:	State:	Zip:	Fax
Email address:			

ATTESTATIONS and CERTIFICATIONS:

I/We hereby certify under the penalties of perjury that to the best of my/our knowledge:

As required by M.G.L.c. 62C, §49A, the applicant has complied with all laws of the Commonwealth related to taxes, reporting of employees and contractors, and withholding and remitting of child support;

The applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health; and

The information included in this application and submitted to the Department related to this application is true.

_____ _____
Officer of Governing Body Date

_____ _____
Executive Director Date

Commonwealth of Massachusetts

County of _____

On this _____ day of _____, 20__, before me, the undersigned notary public, personally appeared the above named persons, proved to me through satisfactory evidence of identification, which were _____ _____, and _____, to be the persons who signed the preceding document in my presence, and who swore or affirmed to me that the contents of the document are truthful and accurate to the best of their knowledge and belief.

_____
Notary Public
My Commission Expires on

Application Documentation:

The following pages list documentation which must be submitted with the application.

All documentation must be included at the time of application submission. **Applications with incomplete documentation will be returned.**

Attach documentation in the order listed, with each item labeled with a separate tab.
Applications not conforming to this requirement will be returned.

Each item of documentation must comply with Appendix B of 105 CMR 164 Licensure of Substance Abuse Treatment Programs. Relevant sections of regulations are listed to the right of each item for reference.

Program Name: **Application Date:** MO_____ YR_____

TAB No.	Application Documentation	Regulation Section
	PROGRAM DESIGN	
1	**Treatment Goals and approach**: Describe applicant's substance abuse treatment, including the following, listed in the order presented below, and identified by letter and topic (e.g. 'a. Treatment Methods'). **a. Treatment Methods:** Describe treatment methods used specifying how treatment methods are expected to achieve program goals. Include standards used to determine appropriateness of methods, identifying which methods are evidence based. **b. Special Populations:** Describe special populations served and design of programs for these populations.	**164.074 (A)(B)(D)(I) (J) 164.082 (A) (B)**
2	**Exclusion Criteria**: Attach policies and procedures describing criteria for excluding individuals	**164.070(G)(H)(I)**
3	**Client Record:** Attach sample of client record forms and formats (**new applications only**).	**164.083 (B)(5)**
4	**Qualified Service Organization Agreements:** If serving pregnant women attach QSOAs for emergency obstetrical and medical back-up for pregnant women	**164.034 164.082**
	PERSONNEL	
5	**Training:** Describe the following, in the order presented below and identified by letter and topic. **a. Orientation of Contract or Temporary Staff** **b. Schedule of monthly in-service training for previous 12 months,** related to substance use disorders, co-occurring disorders, sexually transmitted diseases and viral hepatitis. Include subject, presenter and duration of training session. **c. HIPAA and 42 CFR:** describe method for training staff on requirements of HIPAA and 42 CFR; include frequency, duration and method of documenting participation in training. **d. HIV/AIDS Education:** schedule, including subject, presenter and duration of training to develop staff skills regarding HIV/AIDS	**164,040(A)(20) 164.044 (B)(2)(b,d,e,f); (F) 164.084 164.044(D)**
6	**Supervision of Contract and Temporary Staff:** Identify supervisors of contract and temporary staff; describe schedule and method of supervision and method of documenting supervision.	**164.044 164.047**
	Staffing Pattern:	
7	**Staff List:** Using the table provided, list all staff positions, incumbents, their qualifications, and experience in substance abuse treatment services. Attach resumes.	**164.048 (D)**
8	**Staff Schedule:** Using the tables provided, list nursing and milieu staff schedule for each shift.	

Program Name: **Application Date:** MO_____ YR_____

TAB No.	Application Documentation	Regulation Section
	SUBSTANCE ABUSE TREATMENT SERVICES	
9	**Assessment:** Describe assessment process, listed in the order presented below, and identified by letter and topic. **a. Appropriateness:** Method for determining appropriateness of care in relation to client's treatment need, including standards used to formulate diagnosis **b. Assessment of Infections Disease Risk:** Attach protocols used to assess clients' risks related to HIV and TB. **c. Assessment of Prescription Medications:** Attach protocols used to assess client's current prescription medications in relation to opioid agonist medications **d. Women of Child Bearing Age:** Describe process of completing pregnancy tests prior to administering opioid agonist or prior to detoxification. **e. Consent:** Attach sample of consent form(s); include consent to opioid treatment. **f. Additional Evaluations:** Describe method for obtaining additional evaluations when needed	**164.072 (A) (B) (C) (D) (E) (F) (H) 164.302 (A) (2), (3 b & c), (4, a, e, h)**
10	**Detoxification and Maintenance:** Attach the following: **a. Detoxification Protocols:** All protocols for detoxification from all substances **b. Maintenance:** Protocols followed to establish and adjust dosages for opioid maintenance	**164.133 164.302**
11	**Individual Treatment Plan:** Describe process of developing Individual Treatment Plans	**164.073 (A)**
12	**Treatment Programming:** Attach schedule of substance abuse treatment programming.	**164.133**
13	**Pregnant Women:** Attach protocols followed in providing opioid treatment for pregnant women	**164.304**
14	**Referrals:** Describe process for making referrals for continued substance abuse treatment; include process of referring clients to opioid treatment (methadone and/or suboxone)	**164.074 (J)**

APPENDIX A:
Copies of Current Licenses, Approvals and Accreditations

Program Name: **Application Date:** MO_____ YR_____

STAFF LIST: Include at TAB 7. List below all current directors, senior clinical staff, nursing staff and milieu staff; staff credentials and experience. Attach additional sheets if necessary.

Position	Full Name	Highest Educ. (degree/year)	Years Experience in Substance Abuse Treatment
Program/Clinical Director			
Medical Director			
Master's Level Clinical Staff(specify position)			
Nursing Director			
Nursing Staff:			
Milieu Staff:			

Attach Resumes of Incumbents:

☐ Program/Clinical Director ☐ Medical Director

☐Nursing Director/Supervisor ☐ Senior Clinician specializing in services to youth if serving youth(164.082(B))

Program Name: **Application Date:** MO_____ YR_____

NURSING STAFF SCHEDULE: Include at Tab 8. Attach additional sheets if needed.

Shift	Staff: List Nursing Staff on each shift		
	Full Name	**Position**	**Indicate which days staff person is on duty**
7 am – 3 pm			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
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			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
3pm – 11 pm			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
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			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
11 pm – 7 am			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
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Program Name: **Application Date:** MO_____ YR_____

MILIEU STAFF SCHEDULE: Include at Tab 8. Attach additional sheets if needed.

Shift	Staff: List Milieu Staff on each shift		
	Full Name	**Position**	**Indicate which days staff person is on duty**
7 am – 3 pm			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
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			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
3pm – 11 pm			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
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			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
11 pm – 7 am			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
			☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun
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